North Bay Regional Health Centre

Diagnostic Imaging
Out-Patient CT Scan
Consultation Request

Phone: (705) 474-8600, ext. 2839 / 2820
Fax: (705) 495-7984

Patient Name:_____

Address: _____ City:_____

Health Card #:_____

PHONE #: _____

D.O.B: _____ ❑ Male ❑ Female

❑ Requires Assistance

Is this a WSIB Case? Claim # _____

FAILURE TO COMPLETE THIS REQUISITION IN FULL WILL RESULT IN A DELAY OF BOOKING THE EXAM(S).

AREA TO BE SCANNED	CLINICAL INFORMATION
	Age:_____ Weight:_____ ❑ Pregnant ❑ Currently taking cytotoxic medications

AVAILABLE PREVIOUS ❑ X-RAY ❑ CT ❑ U/S ❑ MRI

Location:_____ Previous Exam Date:_____

DOES THE PATIENT HAVE THE FOLLOWING RISK?

Does your patient have kidney disease or a kidney transplant? OR Has your patient seen or waiting to see a kidney specialist, urologist?	❑ No ❑ Yes

✳✳If you have checked "Yes" there is a risk of contrast-induced acute kidney injury. A current **eGFR is required within 3 months** in order to have exam. Please Fax results to (705) 495-7984✳✳

eGFR _____ Date of Blood Test_____

Adverse Reaction to Contrast Media	❑ No ❑ Yes
Prescribed Metformin	❑ No ❑ Yes
Fluid Restrictions	❑ No ❑ Yes
Dialysis	❑ No ❑ Yes
Does the patient require a substitute decision maker for consent?	❑ No ❑ Yes
Does the patient have a port-a-cath?	❑ No ❑ Yes
Does the patient have a continuous glucose monitoring device?	❑ No ❑ Yes

Signature of Ordering Physician: _____ Print Name of Ordering Physician: _____

For non NBRHC physicians: Please include Ordering Physician # for billing purposes to avoid any delays in care _____

NON-URGENT ❑	**SEMI-URGENT** ❒	**URGENT** ❒
1.5 - 4 Weeks	10 Days	24 - 48 hrs. Call CT Dept. ext. 2839

DI use only:

Procedure Code_____ **Tech Initial** _____ **Rad to Code** ❒

Priority Rating:	Clinical Indication	eGFR Required	Booking Instructions	**Radiologist Verification**
❑ P1 (24hr) ❑ P2 (48hr) ❑ P3 (10days) ❑ P4 (4wks) ❑ T (Timed)	❑ Cancer Staging/Diagnosis ❑ Other	❑ No ❑ Yes	❑ Hydrate Patient	Verify Procedure ❒ Verify Priority ❒ **Rad Initial:**_____

Date Requested: ❑ Yes ❑ No _____

Appointment Booked Date: _____ **Clerk Initial:** _____

Patient Contact Date	**eGFR Check List (Date/Initial)**	**Blood Work Pending**
1)	Computer Note:	Site :
2)	Patient Notified:	Lab Attached (Initial):
3)		